Right care

Making sure the right patient gets the right care

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Preventing errors in patient treatment—right patients right care

One of the main areas where the NHS needs to improve patient safety is the reduction and, where possible, elimination of errors in the matching of patients with their care. There are no accurate figures on the frequency or cost of such mismatching errors but we know from the evidence that is available that they account for a significant proportion of errors made in healthcare. Patient safety incidents can occur, for example, when a patient is given the wrong treatment as a result of a failure to match samples, specimens, or *x* rays; when a patient is given the wrong treatment as a result of a failure in communication or checking; or when one patient is given treatment intended for another as a result of a failure to identify him or her correctly.

In 2000, an expert group chaired by Sir Liam Donaldson, the Chief Medical Officer, noted that adverse events occur in around 10% of NHS admissions or at a rate of about 850 000 patient safety incidents a year.[1] Around half of these incidents are preventable. The UK is not alone in this because research has shown similar rates for patient safety incidents in the US, Australia, Canada, and Denmark. As a result of the expert group's recommendations, the National Patient Safety Agency (NPSA) was established as a special health authority in England and Wales in July 2001. The NPSA's role is to improve the safety of NHS patients by promoting a culture of learning and reporting from patient safety incidents, and to manage the national reporting system to support this function.

Errors in making sure the right patient gets the right care can have a range of consequences. Some errors result in lasting but relatively minor consequences for the patient. Some, however, result in serious, lasting harm, such as chronic pain, undiagnosed cancers, blindness, and even death. For example, between 1996 and 2002 five patients are known to have died directly as a result of being given blood intended for others and six are thought probably to have done so. Sixteen others given the wrong blood died for reasons unconnected with the transfusion.[2]

The NPSA is convinced on the basis of the research it has commissioned (*Mismatching between planned and actual treatments in medicine–manual checking approaches to prevention*, Human Reliability Associates, 2004; and *Ensuring patients are correctly matched with samples or specimens taken from them and treatment planned for them*, Cambridge Consultants, January 2004. To be published by NPSA, http://81.144.177.110) that there is considerable scope in the NHS for improving patient safety by addressing mismatching of care. There is more than one way of approaching this. It could be done through the development of more fail-safe methods of manual identification and checking that does not entail the use of electronic technologies. It could also be approached through the application of modern technologies. The three most likely technologies are: barcoding, which is the most familiar form of ID coding technology using adjacent bars and spaces to present information; radio frequency identification, which uses radio frequency transfer of data between a reader and a tag; and biometrics, which uses automated methods of identifying or authenticating a living person based on physiological or behavioural characteristics.

Whatever system is used to ensure better matching of patients to care, it is highly likely that the patient will need to wear some form of identification bracelet (wristband) or label. The wristband should have printed personal details such as full name, date of birth, hospital number, and ward. However, in addition, information about the patient and their care may be contained in or accessed through a machine readable barcode on the wristband or, in due course, a radio tag in the wristband. A biometric patient identifier, such as an iris scan, could also be coded into a unique number and worn as a barcoded wristband. Thus, the advent of new technologies for matching patients to their care will not make the wristband redundant, but in fact enhance its role and make it increasingly important that wristbands are worn by hospitalised patients.

In some European countries, such as Switzerland,[3] the wearing of wristbands is not systematic and this could make it more difficult to introduce manual and technological innovations to help make sure the right patient gets the right care. Although wearing a wristband as an inpatient is an accepted part of the system in the UK, this does not mean that patients always wear them, or that they are replaced when removed for surgery or procedures such as inserting an intravenous cannula. For example, an audit[4] carried out at Guy's and St Thomas' NHS Trust in July 2000 showed that 34% of patients were not wearing wristbands.

Psychiatric inpatients do not currently wear wristbands in the UK and some people with learning difficulties, mental illness, or personality disorders may be distressed by and resist any attempt to introduce a wristband. Neonates are often too small to retain a wristband and children can be keen to remove them. For patients cared for in the community, wearing a wristband could adversely affect their privacy and dignity.

Wristbands are not always used consistently by staff as part of a systematic process for checking they have the right patient for the treatment or care they are about to give. A recent study showed that 18% of patients receiving blood transfusions did not have their identity checked by staff when the pre-transfusion blood sample was taken (*Safe and effective transfusion in Scottish hospitals – the role of the transfusion nurse specialist*. Gray A, Buchanan S, McClelland DBL, (2003) Unpublished report).

The NPSA is now looking into the use of wristbands as part of its wider initiative on making sure the right patient gets the right care. We will report on this with recommended action for the NHS next year.

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REFERENCES

1 **Department of Health**. *An organisation with a memory*, Report of an expert group on learning from adverse events in the NHS. London: Stationery Office, 2000.
2 **Serious Hazards of Transfusion Organisation**. *Annual report 2001–2002, Serious hazards of transfusion*. Manchester: SHOT, 2003.
3 **Cleopas A**, Kolly V, Bovier PA, *et al*. Acceptability of identification bracelets for all hospital inpatients. *Qual Saf Health Care* 2004;**13**:344–8.
4 **Guthrie D**. *Positive patient identification*. Frontiers in Laboratory Medicine, London: The Royal College of Physicians, 2003.